Discharge Summaries

Printed On Mar 25, 2011

Hx of cocaine use (1996)

ALLERGIES:
NKDA

MEDICATIONS:
ASA prn
Tylenol prn

PHYSICAL EXAMINATION:

Vitals -	TEMPERATURE:	97.8 F [36.6 C] (07/08/2002 08:45)
	PULSE:	65 (07/08/2002 08:45)
	RESPIRATIONS:	16 (07/08/2002 08:45)
	BLOOD PRESSURE:	134/79 (07/08/2002 08:45)

General - alert and oriented, well nourished
HEENT - b/l palpable carotids w/o bruits
Heart - regular rate
Lungs - clear
Abdomen - no pulsatile masses evident
Extremities - LLE cool to touch, without evidence of significant trophic changes; there is noted decreased sensation to temperature, pain, and light touch along the plantar surface of the digits and the anterior plantar surface of the foot; there is no tissue loss or edema.
Pulses -

	brachial	rad	fem	pop	dp	pt
L	+	+	tri	mono	0	extremely turbulent signal
R	+	+	+	biph	0	biph

HOSPITAL COURSE:
The patient was admitted to the vascular service and was immediately started on IV heparin to prevent any further thrombus formation. As part of his vascular work-up, Mr. Johnson was made NPO and scheduled for arteriography of the b/l LEs. Arteriography demonstrated complete occlusion of the infrarenal aorta with reconstitution of the distal left external iliac to the left popliteal artery. The left popliteal artery occludes as well. There was evidence of faint reconsitution of the right SFA. Carotid duplex studies demonstrated patent carotid arteries b/l with < 50% b/l. Lower extremity dopplers demonstrated monophasic flow at the b/l posterior tibial arteries and right dorsalis pedis. There was no signal at the left dorsalis pedis. Right ABI was 0.52. Left ABI was 0.19 at the PT. An aorto-bifemoral bypass was performed on 15 July. Post-operative course was unremarkable, and the patient tolerated the procedure well and pain was managed with PCA morphine. An NGT was placed to assist the patient with complaints of nausea and distension, and the diet was slowly advanced after the NGT was removed. The patient was visited by PT and OT and was subsequently discharged from PT/OT without further recommendations. The patient was discharged with instructions to return to

Discharge Summaries

clinic in 2 weeks and was given Percocet for pain control and Colace.

DISCHARGE MEDICATIONS:
ASA 325 mg PO QD
Percocet 1-2 tabs PO Q4 prn
Colace 100 mg PO BID

DISCHARGE INSTRUCTIONS:
Return to clinic in 2 weeks for examination of incision and instructions for follow-up.

/es/ Kevin C Welch, MD
Otolaryngology -- Head and Neck Surgery Resident
Signed: 07/19/2002 08:08

/es/ STEVEN J BUSUTTIL, MD
SURGICAL ATTENDING, VASCULAR
Cosigned: 10/27/2004 12:50

LOCAL TITLE: Discharge Summary
ADMIN DATE: APR 08, 1996 DISCH. DATE: APR 15, 1996
STANDARD TITLE: DISCHARGE SUMMARY
DICT DATE: APR 17, 1996 ENTRY DATE: APR 18, 1996
DICTATED BY: CARPENTER,JAMES W ATTENDING: SKOTZKO,CHRISTINE E
URGENCY: STATUS: COMPLETED

NAME OF PATIENT: JOHNSON, MAURICE

DATE OF DISCHARGE: 04/15/96
TYPE OF RELEASE: REGULAR
WARD NO: 6B

DISCHARGE DIAGNOSES:
AXIS I: Cocaine dependency.
AXIS II: 0.
AXIS III: 0.
AXIS IV: Unknown.
AXIS V: Unknown.

HISTORY OF PRESENT ILLNESS: This is the first detoxification admission for this 48-year-
old black male. He has been abusing drugs for approximately 35 years. He presently uses
cocaine intravenously and crack cocaine, approximately 50 dollars a day. He drinks
approximately two six packs of beer per week.

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OPERATION REPORT

LOCAL TITLE: OPERATION REPORT
STANDARD TITLE: OPERATIVE REPORT
DATE OF NOTE: JUL 15, 2002@08:14 ENTRY DATE: MAR 16, 2005@10:31:23
SURGEON: EXP COSIGNER:
URGENCY: STATUS: COMPLETED
SUBJECT: Case #: 248913

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* DISCLAIMER: This information is provided from historical files and *
* cannot be verified that the author has authenticated/approved this *
* information. The authenticated source document in the patient's *
* medical record should be reviewed to ensure that all information *
* concerning this event has been reviewed or noted. *
****

NAME OF PATIENT: JOHNSON, MAURICE
SOCIAL SECURITY #: 213-52-4805
DATE OF SURGERY: 07/15/2002
WARD NO:
CASE NO: 248913

ATTENDING PHYSICIAN: QUERAL,LUIS
ASSISTANT:
FIRST ASSISTANT: BOATENG,PERCY
SERVICE:

PREOPERATIVE DIAGNOSIS: Acute aortic occlusion with embolization to the left popliteal artery.

OPERATIONS PERFORMED:
1. Aortobifemoral thrombectomy.
2. Left popliteal thrombectomy.

ANESTHESIA: General.

INDICATIONS FOR OPERATION: Mr. Johnson is a 54-year-old man who presented to the Vascular Service with acute onset of left leg pain with associated left foot numbness and coolness for approximately four days. His evaluation included noninvasive studies, which showed the left ABI at 0.19 and the right ABI of 0.54. His toe pressure on the left was 0 and his toe pressure on the right was 0.35. He underwent an angiogram, which showed an aortic occlusion in the infrarenal portion with reconstitution of the left distal external iliac artery to the left popliteal artery where it re-occluded with an abrupt cutoff indicating possible embolic

Surgical Information

phenomenon. He had a reconstitution of the right SFA without significant flow to the right lower extremity. The patient underwent a necessary preoperative medical workup including carotid studies and a medical pre-evaluation and he was deemed a safe candidate for aortobifemoral reconstruction. The risks and benefits were discussed with the patient. Informed consent was obtained and the patient was brought to the operating room on the day of surgery for the above procedure.

OPERATION: The patient was placed in the supine position. General anesthesia was induced and endotracheal tube was placed without incident. The abdomen and bilateral groins were prepped in a sterile fashion. This was draped sterilely and an Ioban dressing placed on entire surgical field. A midline incision was made from the xiphoid process to the pubis sharply through the skin. This was carried through the subcutaneous tissues to the fascia entering the abdomen transperitoneally without incident. The abdomen was explored and found to be without significant pathology. Following this, the Balfour retractor was placed and the small bowel tacked along the right gutter. The colon and omentum were packed cephalad and using additional handheld retractors, the said exposure of the surgical field was obtained. The duodenum was then reflected off the aorta sharply. Next, we incised the retroperitoneal covering overlying the aorta. Exposing the portion of the aorta just inferior to the point of the crossing of the left renal vein, the dissection was carried around the aorta in a circumferential fashion using a combination of sharp dissection and blunt dissection until the aorta was completely dissected free of its connective tissue covering in a circumferential fashion. After dissection of an area around the aorta, an aortic clamp was passed around the dissected section. This was found to pass freely around the aorta without any difficulty. A red rubber catheter was passed around the aorta, clamped, and protected from the surgical field.

Next, we turned our attention to the groins. Bilateral groin incisions were made over the femoral artery. This was carried through the subcutaneous tissues with a combination of electrocautery and sharp dissection until the SFA was identified. Using further sharp dissection in a cephalad fashion, the common femoral artery was dissected out and next we dissected out the profunda vessels. The vessel loops were passed around all of its arterial branches and the groin incisions were then covered with antibiotic-soaked Ray-Tec sponges.

Next, we turned our attention to create retroperitoneal tunnels for passage of the graft limbs. The retroperitoneum along the course of the external iliac and the common iliac arteries were incised under the abdomen, and using blunt dissection, in an antegrade and retrograde fashion, retrograde femoral-femoral incisions, the retroperitoneal tunnel along the course of the common iliac, external iliac, and the femoral artery were created with the tunnel dissecting through all incisions

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bilaterally. The ureters were identified and protected all through this dissection. Following the dissection, Silastic tube was placed through the tunnels bilaterally to later facilitate passage of the graft. Following creation of the tunnel, the patient was given 5000 units of heparin. After allowing sufficient time for the heparin to circulate, we then proceeded to clamping of the aorta in the area of dissection just distal to the @@@ renal vein. Using the red rubber catheter that had been passed previously as a guide, an aortic clamp was passed behind the aorta completely encircling the aorta. This area was then clamped. A transverse arteriotomy below the point of clamping was then made about half way across the diameter of the aorta. Upon making an incision, we noted medially that there was a large amount of plaque seen in the area of arteriotomy indicating occlusion of aorta proximally and distally from our clamp site. Guess with this, decision was made then to completely transect the aorta. This was done and the distal aorta was then oversewn with #3-0 Prolene suture in a running fashion. Following oversewing of the aorta, we then proceeded to extract the thrombus in the proximal portion of the aorta. Forceps was used to grab the thrombus and @@@ clamp and aligned @@@ from the aorta to dislodge the clot. The clot was then pulled out and large thrombus was extracted from the aorta. Also noted after extraction of the thrombus was a significant amount of atherosclerotic plaque in the area where the thrombus was previously. The thrombus was inspected for a meniscus. One was found indicating a complete extraction of the thrombus. Following extraction of the thrombus, the aorta was temporarily unclamped to ensure unobstructed antegrade flow. This was found to be adequate. Following this, we then proceeded to perform our anastomosis. Using 18 x 9 Hemashield graft, the tube portion was sewn to the aorta in an end-to-end fashion using a running #3-0 Prolene. After completion of the suture line, the distal portion of the graft just prior to the takeoff of the limbs was clamped and next we unclamped the aorta just proximal to our anastomosis and inspected the suture line for hemostasis. This was found to be adequate. Please note that all of the atherosclerotic plaque that was noted previously, especially the thrombus had been debrided prior to performing anastomosis after completion of anastomosis and clamping as above.

Next, we turned our attention to tunneling the graft to the retroperitoneal tunnels. Using the Silastic tube as a guide, Charnley clamps were then passed through our retroperitoneal tunnels from the groins into the abdomen. The graft limbs were then grabbed in sequence and passed out to exit out of our groin incisions bilaterally. Prior to passage of the graft, the graft limbs had been flushed in an antegrade fashion and then reclamped in the tubular portion just prior to the takeoff of the wide limbs. First, we performed an arteriotomy over the left common femoral artery. After vascular clamps had been placed on the distal SFA, the common femoral, and the profunda controlled with the vessel loop, the SFA was checked for retrograde flow. There was some

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flow, but this was minimal. We then proceeded to perform anastomosis in an end-to-side fashion after shortening of the graft limb to provide a tension-free anastomosis and to make sure there was not any slack in the length of the graft in the tunnel. An end-to-side anastomosis was performed using #5-0 Prolene in a running fashion. After completion of anastomosis, the right limb of the graft was then clamped. Following this, the proximal clamp on the tube part of on the graft was removed allowing antegrade flow to the left limb of the graft. This suture line was inspected for adequate hemostasis. This was found to be good and after a few cardiac cycles, the clamp in the right limb of the graft was taken off allowing flushing of the graft once more through the right limb of the graft. Following this, this was clamped again. Then, the vessel loop of the profunda was released followed by the release of the common femoral clamp and then lastly the clamp of the SFA taken off. The distal SFA was checked for pulse and this was found to be present.

Following this, we turned our attention to the right groin. The SFA and the common femoral were then controlled with vessel clamp and the profunda controlled with vessel loop. After this, a longitudinal arteriotomy was performed. The graft limb was cut to appropriate length again ensuring that, that was taut in this tunnel. We then proceeded to perform an end-to-side anastomosis using a #5-0 Prolene suture in a running fashion. Following completion of anastomosis with the vessel clamp still in place and control of the common femoral artery, profunda, and SFA, the right limb grasp clamp was released allowing antegrade flow towards anastomosis. Anastomosis was inspected for hemostasis and this was found to be good.

Next, the vessel clamps were removed by first unclamping the common femoral artery, then the profunda, and lastly the SFA. After completion of groin anastomosis, we then turned our attention back to the abdomen and inspected our aortic anastomosis for hemostasis. This was found to be good. All areas of surgical dissections were inspected for anastomosis. Small bleeding points were controlled with electrocautery. Then, after hemostasis was deemed satisfactory, we proceeded to close the retroperitoneum over our graft using a #3-0 Vicryl suture in a running fashion. After closure of the retroperitoneum over the aortic graft, the abdomen was inspected once more for hemostasis. This was found to be satisfactory. The ureters were identified and found to be intact without any evidence of injury.

We next proceeded to close the abdomen using #2-0 nylon in a running fashion. The fascia was approximated using #2 nylon in a running fashion. Following this, the skin was approximated using staples. After closure of the abdomen, we next turned our attention back to the groin.

Because of the angiographic findings of a possible embolus to his left popliteal artery, we performed a embolectomy of the left popliteal

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artery. The proximal SFA just distal to our anastomosis was clamped with a vessel clamp and at a point further distal, an SFA was chosen and this was controlled with a vessel loop. A transverse arteriotomy was performed. A Fogarty catheter was then passed distally and then withdrawn. There was a fair amount of thrombus that was extracted with the passage of the embolectomy catheter. This thrombus was suspected for a meniscus and the one was found indicating complete embolectomy of the artery. The backflow from the artery was checked and this was found to be vigorous also indicating that all of the thrombus had been extracted. No further debris was noted to backflow into the artery through our arteriotomy site. The arteriotomy incision was then closed using a running #5-0 Prolene suture. The vascular clamps were removed and then the groin incision anastomosis was inspected for hemostasis. A Gelfoam thrombin was used to aid in anastomosis. This was found to be adequate.

The groin incisions were then closed in a two-layer fashion, first using #3-0 Vicryl in the deep layer and then a next superficial layer again with a running #3-0 Vicryl. Following this, the groin incisions were then stapled bilaterally. Sterile dressings were placed in the abdominal incision and groin incisions. The patient was awakened from anesthesia without incident, successfully extubated, transported to the ICU. Sponge and needle counts were correct. He tolerated the procedure well and he was noted to have palpable distal pulses bilaterally.

After closure of the retroperitoneum, the bowel was inspected and found to be viable.

_____

PERCY BOATENG
DICTATING PHYSICIAN

_____

LUIS QUERAL
ATTENDING PHYSICIAN

DD: 07/18/2002
DT: 07/19/2002
INFOPRO /JOB#751906

NURSE INTRAOPERATIVE REPORT

Progress Notes

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LOCAL TITLE: ANESTHESIA POST-OP NOTE
STANDARD TITLE: ANESTHESIOLOGY POST OPERATIVE E & M NOTE
DATE OF NOTE: JUL 09, 2002@08:51 ENTRY DATE: JUL 09, 2002@08:51:59
AUTHOR: BOURKE,DENIS L EXP COSIGNER:
URGENCY: STATUS: COMPLETED

This patient was brought to the OR and anesthetic preparations begun in our usual fashion, including sedation with midazolam. At 0816 we were notified by vascular surgery that Mr. Johnson was not to be the first patient. He was transferred to the PACU sedated in good condition.

/es/ DENIS L BOURKE, MD
CHIEF OF ANESTHESIOLOGY
Signed: 07/09/2002 08:55

LOCAL TITLE: ANESTHESIA PRE-OP NOTE
STANDARD TITLE: ANESTHESIOLOGY PRE OPERATIVE E & M NOTE
DATE OF NOTE: JUL 09, 2002@07:53 ENTRY DATE: JUL 09, 2002@07:53:17
AUTHOR: BOURKE,DENIS L EXP COSIGNER:
URGENCY: STATUS: COMPLETED

History, exam, chart, and labs reviewed, ASA 2. Anesthesia procedures, risks, benefits, and alternatives explained, all questions answered. Anesthetic plan: General endotracheal anesthesia.

/es/ DENIS L BOURKE, MD
CHIEF OF ANESTHESIOLOGY
Signed: 07/09/2002 07:53

LOCAL TITLE: VASCULAR SURGERY NOTE
STANDARD TITLE: VASCULAR SURGERY NOTE
DICT DATE: JUL 09, 2002@00:05 ENTRY DATE: JUL 09, 2002@05:18:20
DICTATED BY: BOATENG,PERCY EXP COSIGNER:
URGENCY: STATUS: COMPLETED

*** VASCULAR SURGERY NOTE Has ADDENDA ***

Name of Patient: JOHNSON, MAURICE

PLACE OF CONSULTATION: Emergency room.

Chief resident admission note.

HISTORY: The patient is a 54-year-old male who presented to the

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emergency room with a complaint of left foot coolnes, pain, and tingling since 07/04/2002. The patient reports that the pain woke him up in the middle of the night and he has had tingling and pain since then. He also reported numbness, which started approximately about the same time in the left foot. He denied a history of claudication and reported he walked approximately three to four miles to work and back and this distance took him about an hour and a half prior to his onset of pain. He noted that he was taking an extra 15 minutes or half an hour to walk the same distance. This was mainly due to pain he was experiencing in his calf on the left side. He denied any tissue loss. He denied any history of TIAs, chest pain, SOB DOE.

PAST MEDICAL HISTORY: The patient did not have any history of hypertension or diabetes or heart disease.

SOCIAL HISTORY: Significant for half a pack a day smoking history for 30 years.

MEDICATIONS: None.

ALLERGIES: None.

PHYSICAL EXAMINATION: General: The patient is a well built and well nourished. Vascular Examination: Significant for palpable carotids bilaterally w/o bruits, brachials and radials bilateral. There was
no pulsatile abdominal mass. He had palpable femorals bilaterally but diminished. He had a popliteal signal by Doppler only bilaterally and he had a PT and DP on the right and a PT only on the left side. His left forefoot was cool to touch and this demarcated at the ankle. He
had slightly decreased sensation to light touch of his forefoot and toes.His motor function - moving his toes- was diminished compared to the right. his right foot was warm.
There was no evidence of tissue loss. Chest: Clear. Heart: Regular rate and rhythm. Abdomen: Soft with no organomegaly. Extremities: He had no clubbing or cyanosis.

ASSESSMENT: This is a 54-year-old gentleman with no significant past medical history whose only comorbidity is a history of smoking who presents with a four-day history of right foot pain, numbness, and paresthesias, but no evidence of tissue loss. This numbness includes coolness. This finding is consistent with acute limb ischemia and the patient needs to have an emergent assessment with angiography to determine the level of occlusion. He is also being sent to the Vascular Lab to get formal ankle-brachial indices; then he will be sent down to Radiology for his

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angiography. After angiography, the patient will be heparinized while pending surgical decision making as to correction of this acute limb ischemia. At present still have motor function. The patient has been discussed
with Dr. Annie Cheanvechai and she agreed to the plan.

DD: 07/09/2002
DT: 07/09/2002
INFOPRO /JOB#727430

/es/ PERCY BOATENG, MD
SURGICAL RESIDENT
Signed: 07/09/2002 09:00

07/11/2002 ADDENDUM STATUS: COMPLETED
The pt's systolic arm pressure was 112 on the R. and 124 on the L.

/es/ PERCY BOATENG, MD
SURGICAL RESIDENT
Signed: 07/11/2002 09:18

LOCAL TITLE: 24 HOUR PATIENT CARE RECORD
DATE OF NOTE: JUL 09, 2002@03:23 ENTRY DATE: JUL 09, 2002@03:23:35
AUTHOR: BELICH,JOSEPH M EXP COSIGNER:
URGENCY: STATUS: COMPLETED

*** 24 HOUR PATIENT CARE RECORD Has ADDENDA ***

TYPE AN "X" TO INDICATE SHIFT AND TYPE OF CLASSIFICATION:
[X] N 2230-0800 [ ] D [ ] E
CLASS:3

SAFETY
[ ] aspiration [ ]seizures [ ]DNAR [ ]falls [ ]wanderer

CENTRAL NERVOUS SYSTEM: Normal, alert, oriented to person, place, time, follows commands; speech clear.
[X] within normal limits
[ ] disoriented
[ ] confused
[ ] lethargic
[ ] drowsy

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COAGS TEST OF mR JOHNSON PT =12.9,PTT=147,inr=1.17,ON PHISICAL THE LOWER EX PHISICAL HAS NOT BEEN CHANGED ,THERE IS STILL NUMBNESS IN SAME FOOT THAT HAD BEFORE WITH THE SAME QUANTITY AND QUALITY ,NEUROLOGICAL EXAM IS INTACT WITH MINIMAL LOSS OF SENSATION AND COLDNESS IN THE SAME FOOT .NO PROGRESSION AND WORSENING PAIN IS STATED.PHONECALL WAS MADE TO CHIF RESIDENT FOR FOLLOW UP AND THE DECISSION WAS MADE TO COUNTINUE HEPARINISATION WITH 900U PER HOUR AND RECHECK HTE COAGS STUDY AT 5 AM TO REAVALUATION.THE SITE OF ANGIOGRAPHY ON THE LEFT ARMPIT WAS SOAKED MINIMALLLY THERAFTER PACKING THE SITE WAS PERFORMED.
THANK YOU
AFSHIN ESLAMI

/es/ AFSHIN ESLAMI, MD
SURGICAL RESIDENT
Signed: 07/09/2002 03:01

LOCAL TITLE: RADIOLOGY NOTE
STANDARD TITLE: RADIOLOGY NOTE
DATE OF NOTE: JUL 08, 2002@17:52 ENTRY DATE: JUL 08, 2002@17:52:14
AUTHOR: MCCORMAC,JOHN A EXP COSIGNER:
URGENCY: STATUS: COMPLETED

Interventional Radiology Procedure Note

Procedure:
Abdominal Aortogram
Pelvic Arteriogram
Right lower extremity runoff arteriogram
Left lower extremity runoff arteriogram

Medical Diagnosis: Acute L foot coldness, numbness, pain

Indication: claudication of L foot, abnormal ABI

Physicians: Drs. Pais, McCormac

Anesthesia: Intravenous sedation, Local lidocaine Contrast 250 cc

Description of Procedure: The risks, benefits, and alternatives of the procedure and were discussed and informed consent was obtained. The L axilla was prepped and draped using standard technique. A 5 Fr sheath was inserted into the L axillary artery using a Seldinger technique.

Arteriography of the following vessels were performed with catheterization technique as follows:

Abdominal and pelvic aortography using a 5 Fr catheter over a Bentson

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guide wire. R and L runoff aortograms via a 5 Fr catheter.

The arteriotomy site was closed using manual compression successfully. There were no complications. Dr. Pais was present for the entire procedure. The results were reviewed with the vascular surgery team.

Findings:
Distal abdominal aortography demonstrates patent renal arteries with infrarenal aortic occlusion. Collaterals are seen. Pelvic angiogram demonstrates reconstitution of the left distal external iliac artery with patent profunda and SFA. This segment occludes at the L popliteal with no flow seen distal. There is faint reconstitution of the right SFA with poor flow. This can not be seen into the region of the popliteal.

Impression:
1. Infrarenal aortic occlusion
2. Distal external iliac reconstitution occluding again at the L popliteal artery.
3. Faint R SFA reconstitution without significant flow.

/es/ JOHN A MCCORMAC
JOHN A MCCORMAC
Signed: 07/08/2002 18:00

LOCAL TITLE: VASCULAR SURGERY NOTE
STANDARD TITLE: VASCULAR SURGERY NOTE
DATE OF NOTE: JUL 08, 2002@13:45 ENTRY DATE: JUL 08, 2002@13:45:05
AUTHOR: LEHRFELD,TODD J EXP COSIGNER:
URGENCY: STATUS: COMPLETED

*** VASCULAR SURGERY NOTE Has ADDENDA ***

CC: Painful Left foot

Pt is a 54 yo aa m c pmh signif only for 30+pack year smoking hist, questionable ivda in the past presenting this am to BVAMC ED c c/o severe L foot pain since friday at 4AM. vet states he was in USH prior to this, when he was suddenly awoken from sleep c severe pain in L toes, c some less painful areas on forefoot and medial aspect of LLE. Pain has been fairly constant since this time, c assoc pallor, coldness, and decreased mobility. Pt states he took some aspirin for the pain, but it did not help.

PMH/PSH- none